MURRAY CITY CORPORATION

SUPERVISOR'S REPORT OF INJURY OR ILLNESS

Warning: "Worker's Compensation insurance fraud is a crime punishable by Utah law."

Location (print)_____ Department_____ Phone Number_____
Employee Name_____ Date of Birth_____ Employee #_____
Address_____ City_____ Zip Code_____
Married ❑Y ❑N Gender ❑M ❑F Age_____
Job Title_____ Length of Service with Murray City_____years
Hourly Wage Rate_____ Job Being Performed at Time of Injury _____
Description of Incident:_____

EMPLOYEE

Release of Medical Information

I certify that the above information is true to the best of my knowledge and I authorize the release to Murray City and to Workers' Compensation Fund, all records relevant to my disability and my claim for disability of workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. This authorization applies to physicians and other health care providers, hospitals and clinics, insurance companies and workers' compensation carriers. This authorization will remain in effect throughout my claim for workers' compensation benefits. A photo copy of this authorization will be as valid as the original.

Employee Signature_____ Date_____

SUPERVISOR

INCIDENT DETAILS

Date of Incident_____ Time of Incident_____ ❑AM ❑PM Date Reported_____
Shift ❑Days ❑Afternoons ❑Graveyard ❑Other Was Employee on Overtime? ❑Y ❑N Time Shift Commenced_____
Incident Location (specific area)_____ On Employer Premises? ❑Y ❑N
Witness(es) to incident_____
Did Employee lose time due to the injury? ❑Y ❑N First Aid Given? ❑Y ❑N
Date & Time Employee left work?_____ Date & Time Employee returned to work?_____
Complete if Applicable: Medical Facility_____ Doctor_____ (If Medical Attention is Sought, Complete the Workers' Compensation First Report of Injury Form)
Follow up appointment scheduled? ❑Y ❑N
Was time off authorized by the physician? ❑Y ❑N If yes, how many days?_____
Treatment given ❑Prescription ❑Irrigation ❑Sutures ❑Tetanus Shot
❑Brace ❑Cast ❑Ace Bandage ❑Removal of Foreign Object
❑None ❑Other_____

PART OF BODY INJURED - MARK ALL THAT APPLY

❑Head	❑Eye (L or R)	❑Back (upper or lower)	❑Toe (Identify)	❑Abdomen
❑Face	❑Shoulder (L or R)	❑Elbow (L or R)	❑Forearm (L or R)	❑Trunk
❑Nose	❑Arm (L or R)	❑Ribs (L or R)	❑Leg (L or R)	❑Chest
❑Neck	❑Hands (L or R)	❑Hip (L or R)	❑Thigh (L or R)	❑Foot (L or R)
❑Skin	❑Knee (L or R)	❑Ankle (L or R)	❑Finger(Identify)	

❑Other(describe)_____

NATURE OF INJURY - MARK ALL THAT APPLY

❑Abrasion ❑Exposure - Chemical ❑Puncture ❑Inhalation ❑Burn: Heat or Chemical

❑Bruise - Crushed ❑Fracture - Dislocation ❑Hearing Loss ❑Fatality ❑Laceration - Cut

❑Sprain ❑Exposure: Heat or Cold ❑Amputation ❑Dermatitis ❑Poisoning - Systematic

❑Strain ❑Foreign Object ❑Other(describe)_____

INVESTIGATION

Date of Investigation_____ Person(s) Making Investigation_____

Employee's Supervisor (print name)_____ Supervisor's Phone Number_____

Who was immediately in charge at the time of injury?_____

Was Employee Task Trained? ❑Y ❑N If yes, explain_____

Were Safety Codes/Rules Violated? ❑Y ❑N If yes, explain_____

Equipment Involved: Type_____ Model #_____ Manufacturer_____

CAUSE OF INJURY - MARK ALL THAT APPLY

❑Body Motions ❑Bldg/Structures ❑Chemicals ❑Hot/Cold Temperatures

❑Infectious Agents ❑Vehicles ❑Conveyers ❑Electrical - HV

❑Electrical - LV ❑Falling Objects ❑Ladders ❑Flame/Fire/Smoke

❑Flying Objects ❑Flash ❑Noise ❑Furniture/Fixtures

❑Hoisting Apparatus ❑Machines - Misc. ❑Particles ❑Hand Tools - Non Power

❑Hand Tools - Power ❑Sharp Objects ❑Slip/Trip/Fall ❑Other_____

SUPERVISOR

CAUSE OF INCIDENT - MARK AND EXPLAIN ALL THAT APPLY

❑Equipment Failure ❑Improper Material Handling ❑Excessive Speed ❑Poor Housekeeping

❑Lack of Attention ❑Wet/Slippery/Uneven Surface ❑Procedure Failure ❑Fatigue

❑Horseplay ❑Other_____

ANALYSIS

Description of Incident

_____

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STEPS TAKEN TO PREVENT SIMILAR OCCURRENCE - MARK AND EXPLAIN ALL THAT APPLY

❑Reinstruction of Employee Involved ❑Reminder Instruction of all Employees

❑Personal Protective Equipment Required ❑Formal Disciplinary Action

❑Installation of Guard Device ❑Counseling of Employees

❑Other_____

Supervisor Signature_____ Date _____

Reviewed by_____ Date _____

_____Health & Safety Manager

Rev. 06/2004